MEDI-CAL UPDATE Part 2
Billing and Policy
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Long Term Care

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Contents

HIPAA-Mandated HCBS Waiver Code and Policy Changes

Effective for dates of service on or after November 1, 2006, the Home and Community-Based Services (HCBS) waiver program will update billing codes from interim HCPCS codes to national HCPCS codes to streamline the billing process.

All existing waivers remain valid until the date of their expiration.

A total of 15 new waiver procedure codes will correlate with select modifiers and provider types in order to produce one reimbursement rate. All HCBS interim HCPCS codes starting with the letter "Z" will be replaced by the national codes.

The HCBS waivers administered by In-Home Operations (IHO) are restructured to reflect the medical facility alternative that the waiver serves.

- **In-Home Medical Care (IHMC) Waiver:** This waiver remains unchanged. It serves disabled recipients who, in the absence of waiver services, would otherwise require acute hospital services for at least 90 consecutive days.
- **Nursing Facility Subacute (NF-SA) Waiver:** This new waiver serves disabled recipients who, in the absence of waiver services, would otherwise require adult or pediatric subacute NF inpatient services for at least 180 consecutive days.
- **Nursing Facility Level A and B (NF-A/B) Waiver:** This waiver replaces the Nursing Facility (NF) Waiver. It serves disabled recipients who, in the absence of waiver services, would otherwise require NF-A (intermediate care) or NF-B (skilled nursing facility) services for at least 365 consecutive days.
- **Model-Nursing Facility Waiver:** This waiver was terminated. Recipients were transitioned to either the NF-SA or NF-A/B Waiver based on the recipient's facility alternative level of care.

Long Term Care Codes

Long Term Care (LTC) providers must use interim codes, depending on the level of care, for intermittent or regularly scheduled temporary care and supervision provided to an individual in an approved LTC facility, per day. LTC facilities must submit prior authorization requests using a *Long Term Care Treatment Authorization Request* (20-1 form) and submit claims on the *Payment Request for Long Term Care* (25-1) claim form. All reimbursements are contracted with Medi-Cal on a daily per diem basis.

2007 ICD-9 Diagnosis Code Update

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after October 1, 2006. Providers may refer to the *2007 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptors.

Additions
The following ICD-9 diagnosis codes are new:

052.2	053.14	054.74	238.71
238.72	238.73	238.74	238.75
238.76	238.79	277.30	277.31
277.39	284.01	284.09	284.1
284.2	288.00	288.01	288.02
288.03	288.04	288.09	288.4
288.50	288.51	288.59	288.60
288.61	288.62	288.63	288.64
288.65	288.69	289.53	289.83
323.01	323.02	323.41	323.42
323.51	323.52	323.61	323.62
323.63	323.71	323.72	323.81
323.82	331.83	333.71	333.72
333.79	333.85	333.94	338.0
338.11	338.12	338.18	338.19
338.21	338.22	338.28	338.29
338.3	338.4	341.20	341.21
341.22	377.43	379.60	379.61
379.62	379.63	389.15	389.16
429.83	478.11	478.19	518.7
519.11	519.19	521.81	521.89
523.00	523.01	523.10	523.11
523.30	523.31	523.32	523.33
523.40	523.41	523.42	525.60
525.61	525.62	525.63	525.64
525.65	525.66	525.67	525.69
526.61	526.62	526.63	526.69
528.00	528.01	528.02	528.09
538	608.20 *	608.21 *	608.22 *
608.23 *	608.24 *	616.81 **	616.89 **
618.84 **	629.29 **	629.81 ** +	629.89 **
649.00 ** +	649.01 ** +	649.02 ** +	649.03 ** +
649.04 ** +	649.10 ** +	649.11 ** +	649.12 ** +
649.13 ** +	649.14 ** +	649.20 ** +	649.21 ** +
649.22 ** +	649.23 ** +	649.24 ** +	649.30 ** +
649.31 ** +	649.32 ** +	649.33 ** +	649.34 ** +
649.40 ** +	649.41 ** +	649.42 ** +	649.43 ** +
649.44 ** +	649.50 ** +	649.51 ** +	649.53 ** +
649.60 ** +	649.61 ** +	649.62 ** +	649.63 ** +
649.64 ** +	729.71	729.72	729.73
729.79	731.3	768.70 #	770.87 #
770.88 #	775.81 #	775.89 #	779.85 #
780.32	780.96	780.97	784.91
784.99	788.64	788.65	793.91
793.99	795.06 **	795.81	795.82
795.89	958.90	958.91	958.92

Please see **ICD-9 Codes**, *page 3*

ICD-9 Codes *(continued)*

Additions (continued)

958.93	958.99	995.20	995.21
995.22	995.23	995.27	995.29
V18.51	V18.59	V26.34 *	V26.35 *
V26.39 *	V45.86	V58.30	V58.31
V58.32	V72.11	V72.19	V82.71
V82.79	V85.51	V85.52	V85.53
V85.54	V86.0 ** +	V86.1 ** +	

Restrictions

* Restricted to males only
** Restricted to females only
# Restricted to ages 0 thru 1 year
\+ Restricted to ages 10 thru 99

Inactive Codes

Effective for dates of service on or after October 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

238.7, 277.3, 284.0, 288.0, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, 333.7, 478.1, 519.1, 521.8, 523.0, 523.1, 523.3, 523.4, 528.0, 608.2, 616.8, 629.8, 775.8, 784.9, 793.9, 995.2, V18.5, V58.3, V72.1

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

255.10, 285.29, 323.1, 323.2, 323.9, 333.6, 345.40, 345.41, 345.50, 345.51, 345.80, 345.81, 389.11, 389.12, 389.14, 389.18, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 524.21, 524.22, 524.23, 524.35, 600.00, 600.01, 600.20, 600.21, 600.90, 600.91, 780.31, 780.95, 790.93, 873.63, 873.73, 995.91, 995.92, 995.93, 995.94, V26.31, V26.32

Instructions for Manual Replacement Pages — Part 2

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Remove and replace: forms reo 1/2 *

Correction: The August 2006 *Medi-Cal Update* included the manual replacement pages mc sup lst3 13/14. These pages do not belong in the Long Term Care provider manual. Please disregard.

* Pages updated due to ongoing provider manual revisions.